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Orders of worth and the moral conceptions of health in global politics

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The article analyzes the contested concept of global health through the lens of orders of worth. Drawing on pragmatist political and social theory, especially the work of Boltanski and Thévenot, I conceptualize orders of worth as moral narratives that connect visions of universal humankind to ideas about moral worth and deficiency. They thereby differ from the self/other narrative of political identity that is emphasized in International Relations scholarship. Orders of worth do not pitch a particularistic identity against foreign identities, but tie collective identity to a higher common good. They provide tools for moral evaluation and the justification of hierarchy. I use this heuristic to reconstruct four main conceptions of health in global politics: The order of survival, the order of fairness, the order of production, and the order of spirit. Each of them articulates a distinct political identity, as 'we species', 'we liberals', 'we bodies' and 'we souls', and implies different notions of virtuous and selfish conduct in the global community. These orders are derived from scholarly writings and the policies of global health institutions. Finally, I discuss the nature of compromises between the four orders regarding contested issues such as health emergencies or digital medicine.

Keywords: pragmatism; global health; orders of worth; health ethics; identity; valuation sociology

The Ebola catastrophe that broke out in West Africa in 2014 has again alerted the global public to the problem of 'culture' in global health governance. Burial rituals and church assemblies are identified as dangerous sources of contagion, and international health agencies rely on anthropological advice to promote 'culturally sensitive' containment measures in the affected countries (Abramowitz *et al*. 2015). This reaction is emblematic of the modern view of global health governance, where culture is a feature of the 'pre-modern' policy targets. What this perspective overlooks, however, are the cultural codes in which 'modern' global health policies and institutions themselves are embedded. The biological connotations of health and the massive deployment of scientific (medical, economic, and public health) expertise contribute to the perception that culture is irrelevant to the making of global health policies.

The cultural valuations and conflicting moral conceptions that inform these policies are hidden behind rationalized models and the universal language of one 'global' health.

In this article, I reverse the perspective and offer a cultural reconstruction of global health politics. Drawing on pragmatist social and political theory and especially the work of Boltanski and Thévenot, I will uncover how the meaning of global health is established through different ways of imagining humankind and its higher common good. Different perspectives on global health will be conceptualized as 'orders of worth', which I define as repertoires of evaluation consisting of moral narratives and objects that enable tests of worth. Each order of worth is defined by a higher common good that delineates the collective identity of the political community, and that is established in opposition to a dystopian vision of threats to this community. The visions of the common good justify moral hierarchies between individual or collective actors by specifying the meaning of worthy sacrifices and deficient selfishness. I will distinguish between four major orders of worth in global health and their conceptions of the global community, as a community of species, of liberals, of bodies, and of souls. Each of these conceptions is based on a different idea of health as a common good – the common goods of survival, fairness, production, and spirit, respectively – and provides different criteria for distinguishing a virtuous sacrifice from a selfish pleasure.

This reconstruction of the moral repertoires of global health starts from the observation that health is both highly valued and essentially contested in global politics. 'Health' has undoubtedly become a powerful ideal in global politics, and its cause is promoted by a wide range of actors. Nowadays, national agencies such as the US Agency for International Development, professional associations such as the International Council of Nurses, philanthropists such as the Bill and Melinda Gates Foundation, NGOs such as Médecins Sans Frontières, intergovernmental organizations such as the World Health Organization (WHO), business associations such as the International Federation of Pharmaceutical Manufacturers & Associations, and the myriad partnerships entertained by these organizations seek to promote 'global public health'. Global health expenditures have skyrocketed, too. International health assistance flows have risen from US$ 6.9 billion in 1990 to US$ 35.9 billion in 2014 (Dielemann *et al.* 2015). This increase in governance efforts indicates the rise of a powerful, if not 'superordinate' (McInnes and Rushton 2014, 835) moral category to the global stage. 'Health' evokes intense moral sentiments. It is both a universal and a most intimate value, shaping how we see and feel about ourselves, and how we can participate in social and political life. Unlike practically all other policy fields, in the domain of health the need for public authority and redistribution is

hardly controversial, and expectations of fundamental equality are strong (Carpenter 2012). Furthermore, health is closely connected to what are held to be the most universal norms of global politics: physical integrity and equality of opportunity (Keck and Sikkink 1998, 27). It seems that health 'is a difficult thing to argue with' (Howell 2012, 315).

At the same time, however, the meaning of 'health' is deeply ambiguous. Despite its biological, 'natural' connotations, health is 'essentially contested'. Health can refer to varied ideals including well-being, wholeness, vitality, autonomy, or the possession of risk-free genes. The ambiguity of the term is also evident in the preamble of the WHO constitution. It stipulates that health is 'a state of complete physical, mental and social wellbeing, and not merely the absence of disease and infirmity' (WHO 2006, 1) – an ideal that can be, and that has been associated with many rival interpretations.

Contemporary conflicts about the 'right' moral conduct in global health illustrate the contested substance of this ideal. A prominent example is the conflict over Indonesia's decision in 2006 to stop sharing 'its' strains of avian flu viruses within the WHO network of laboratories. Indonesia justified this move in the language of fairness. It pointed to incidents where other countries and companies had used the information shared by Indonesia to develop and patent pharmaceuticals, which were then unaffordable for Indonesians (Sedyaningsih *et al*. 2008). While its initiative to renegotiate the terms of virus- and benefit-sharing in the WHO was supported by many developing countries, which heralded Indonesia as an advocate of health equity (Hammond 2009), others criticized Indonesia's stance in the language of survival. They condemned Indonesia's 'morally reprehensible' behavior as a selfish move that jeopardized the health of human beings around the globe (Holbrooke and Garrett 2008). Like in many conflicts about 'global health', each of the parties could make strong moral claims and state that it had the non-negotiable value of 'health' on its side.

An analysis of the evaluative repertoires that underpin such controversies contributes to several debates. First, it sheds new light on the ambiguous concept of health in global politics, which is rarely problematized in the scholarship on global health governance. I will argue that even the literature on different 'framings' of global health ultimately black-boxes the concept of health by making it an unproblematic reference point for the evaluation of policy frames and their effectiveness. Second, it contributes to International Relations (IR) discussions about the making of collective identity. It takes up the idea that a turn to the body questions the 'self/other' logic of identity, and discusses how ideas about our common humanity are tied to justifications of moral inequality. Finally, the analysis contributes to the scholarship on international practices and its interest in the social background knowledge

that enables competent practices. Orders of worth are a form of moral background knowledge and provide the practical devices – cognitive tools, symbols, institutions, and roles – to create and contest moral hierarchies.

The remainder of this article is divided into five sections. The following section discusses the limits of existing theorizations of global health, and argues that unpacking the concept of health also enhances IR debates about collective identity. Next, I introduce the heuristic of orders of worth and their constitutive elements. The third section is dedicated to the reconstruction of the four orders – survival, fairness, production, and spirit. They are derived from the global health literature and a survey of contemporary global health institutions, their cognitive tools, valued social roles, and major policies. The fourth section discusses the nature of compromises between these irreducible evaluative repertoires. I suggest that compromises are situated and creative constructions, which do not follow an overarching rationale (such as 'global biopolitics') or principled hierarchy between the four orders. The final section summarizes the argument and its implications for global health and IR research.

Frames, narratives, and the health of the global community

Health is a political concept. Its use not only indicates how the individual body is conceived, but also a moral aspiration through which the individual and the political body are tied together and connected to notions of virtue, normalcy, nature, and even peace. A classic example of health as a central stake of political morality is provided in the second book of Plato's *Republic*. Plato develops a thought experiment about the degeneration of an initially virtuous and healthy state into an afflicted state in need of political authority. In this account, ill-health results from a break with an original spontaneous harmony and is due to moral failures such as greed and decadence. This decline is accompanied by wars of conquest and the need for more doctors, thus showing that both the community and the individual are sick and in need of a political cure (Platon 1985, 58–66). In Plato's case, the cure is a regime of both individual and collective moderation, ensured by the rule of philosophers.

Evidently, new political ideas and new medical technologies have reshaped visions of the healthy self and the healthy community since Plato's time. Yet the basic insight remains, namely, that health is a moral ideal that is tied to political questions of who we are, how we should live, and how we should live together. This political nature of health is increasingly debated in the scholarship on global health governance, which pays growing attention to alternative social constructions of health in global politics.

In the following, I will discuss how this literature exposes the multiple 'framings' of health in global politics, but nevertheless black-boxes the very concept of health. I go on to argue that a deeper understanding of the concept of health is not only needed to comprehend health policy conflicts, but also to enhance IR debates about the 'bodily' foundations of political communities.

What's in a frame?

Scholars of global health governance increasingly emphasize that global health is not a biological given, but a deeply politicized concept. For some, this politicization implies that 'politics' affects 'health' services from the outside, for example, when medicine becomes a tool of foreign policy (McInnes and Rushton 2014). More fundamentally, global health scholars have become interested in how the notion of global health itself is socially constructed. To account for the variable meanings of global health, several authors have relied on the framing approach in the tradition of Goffman. This approach highlights that phenomena in themselves do not determine their social meaning, but require active social construction to become socially meaningful (Goffman 1974). They must be connected to an interpretive 'frame'.

The framing perspective on global health has made it clear that there is not one dominant use of the term, but that several frames are used in global health politics. For example, Inoue and Drori (2006, 212) carried out a quantitative, macro-sociological analysis in the tradition of the Stanford world culture school, which identifies a historical succession of four main 'themes' and 'visions' informing the self-descriptions of international health organizations. They argue that dominant framings of health have proceeded from health as an act of charity (16th–19th century), as a professional activity (late 19th century), as a tool for economic development (post-World War II), to health as a basic human right (post 1990). Although these themes were institutionalized at different points in history, the study's focus on organizations that have survived until the 21st century means that all four themes coexist in today's 'world culture' of global health.

In a similar vein, a collaborative comparative study involving seven broadly constructivist global health scholars distinguished five framings of global health and their use in conflicts over HIV/AIDS, pandemic influenza, or tobacco control policies. These five frames are evidence-based medicine, economics, development, security, and human rights (Reubi 2012; McInnes *et al*. 2014). The security frame in particular is an important addition to the Keiko *et al*. study, taking account of the growing

'securitization' literature on global health (see below). Emphasizing that global health is a 'socially constructed reality' (McInnes *et al.* 2014, 15), the authors process-trace the ways in which different framings have been used strategically by political actors and made health policies more or less 'effective' (McInnes *et al.* 2014, 16). They argue that there is a disconnect between objective and perceived health problems, because 'material conditions were not sufficient for a global health problem to arise' (McInnes *et al.* 2014, 98). Furthermore, they stress that health issues are usually connected to 'other issues on the global political agenda' such as security or development (McInnes *et al.* 2014, 99) in order to gain political support.

These studies of alternative framings of global health reveal the plurality of meanings that are given to health in global politics. Yet, they also expose the limitations of the frame analytical approach to global health, namely a lack of concept specification and an ultimately objectivist approach to the meaning of health. For the first limitation, it must be noted that the framing approach is more concerned with the process and the strategies of framing than with the substance of frames (Goffman 1974). A frame is often defined very broadly, as that which is socially constructed. More narrowly, the social movement literature speaks of 'collective action frames', which present issues as a specific type of problem in need of a specific policy solution (Benford and Snow 2000; Payne 2001, 39). Yet, also from the viewpoint of this conceptualization, it remains unclear whether frames of global health are about problems or solutions, or both. The studies about global health frames oscillate between categories that frame global health as a 'problem' – for example, a problem of 'security', 'development', or 'human rights' – and framings of policy 'solutions' for global health – for example, 'evidence-based medicine', 'economics', or 'charity'. The meanings of the proposed frames remain underspecified und underline the need for a finer conceptualization.

The second limitation is that the framing approach to global health is ultimately objectivist. It remains tied to the presupposition that the 'material conditions' (McInnes *et al.* 2014, 98) of global health are self-evident, and that frames can reflect them more or less adequately. Health is thus that which can be furthered more or less 'effectively' through different policy framings (McInnes *et al.* 2014, 16). This requires that health be kept stable, as an objective benchmark for comparing the impact of alternative policy frames. Similar to the general thrust of framing research, which treats actors and their grievances as given and then analyzes their success in changing policy (Benford and Snow 2000, 618–19), the frame analyses of global health assume an unproblematic reality of health – something to which frames are added in order to promote the cause of health. Hence, the question how 'health' is institutionalized 'as a social concern' (Inoue and Drori 2006, 199) still presumes that health can also *not*

be a social concern, and that it exists prior to social debates about it. Thereby, the *underlying narratives* that constitute health in the first place remain outside of the purview of frame analysis (see Klotz and Lynch 2007, 55). An analysis of these very background narratives points to fundamental questions about the conception of the global community.

Global health and narratives of political community

A conceptual analysis of 'global health' not only sheds new light on the normative assumptions and tensions that undergird this policy field, but also questions central concepts of IR and advances debates about the meaning of political identity in global politics. As scholars investigating the securitization of health have emphasized, the 'global health security' discourse not only increases the salience of health policy in world affairs (Elbe 2009); it also gives a new meaning to the notion of 'survival', which is no longer primarily a concern of the sovereign state, but refers to other entities such as individuals, populations, or patients, and thereby legitimizes authority transfers to global institutions (Davies *et al.* 2014, 828; Hanrieder and Kreuder-Sonnen 2014; see below, The order of survival section).[1]

By referring to a 'biological' rather than national community, the rise of global health indeed challenges established IR conceptions of the political community. IR notions of collective identity are classically based on a self/other ontology of identity (Neumann 1996). Communities are imagined in opposition to other communities, and narratives about these communities need to characterize the respective self and its other (Campbell 1992; Krebs 2015). Yet, as Neumann has pointed out with reference to Lacanian scholarship on the idea of the self, our '*bodily* similarity' is of 'enormous' political significance for how we conceptualize collective identity (1996, 145, emphasis in original). It undermines attempts at boundary drawing between communities, and rather suggests drawing a 'parallel […] between the body and the body politic' (Neumann 1996, 145).

This problem has been further explored in Bartelson's (2009) genealogy of ideas about 'world community'. In an effort to deconstruct the widely held assumption that a community must be based on particularistic identities, Bartelson reconstructs universalistic conceptions of world community since the Late Middle Ages. He thereby claims that a community need not be based on boundary drawing and self/other dynamics, but can be established by reference to 'a cosmological vantage point situated over and above the plurality of human communities and the multitude of individual human beings' (Bartelson 2009, 181). Such a vantage point makes it possible

[1] But see Price-Smith (2009) on disease as a threat to state capacity.

to see how all human beings 'are sharing certain capacities in common that make it possible for them to share other things as well' (Bartelson 2009, 44). In other words, communities can also be imagined on the basis of ulterior principles and shared capacities that subvert the in-group/out-group conundrum (see Walker 1993). This approach is particularly suited to reconstructing conceptions of the biological unity of humankind, and thus to debates about health in global politics. In fact, Bartelson concludes his study with the suggestion that we shift our attention to our bodily interdependence on an endangered planet, a move which can foster new and solidary notions of world community. 'Today', he writes, we are facing 'the task of reformulating our concept of community in the light of our cosmological beliefs about the human habitat [which is] the philosophical import of problems of climate change and sustainability' (Bartelson 2009, 181–82).

The following conceptualization of orders of worth follows up on this call to imagine community with reference to distinct 'cosmologies' and universal vantage points. Orders of worth do precisely this: they imagine community on the basis of fundamental assumptions about human identity and the common good. Yet, whereas Bartelson (2009, 182) stops at heralding the anti-imperialist potential of seeing us as equal parts of one 'nature', the orders of worth approach also spells out how moral hierarchies are justified within and through different conceptions of a universal community. It offers a heuristic for capturing how moral inequality is established through specific vocabularies describing a community's higher common good, the worthy sacrifice that fosters it, and the deficient selfishness that jeopardizes it.

Orders of worth

I define orders of worth as repertoires of evaluation consisting of moral narratives and objects that enable tests of worth. This conceptualization is based on a pragmatist approach to justification, which conceives of evaluations as cultural practices (cf. Lamont 2012). Specifically, I draw on the works of Rorty and of Boltanski and Thévenot. Rorty's pragmatist political theory emphasizes that moral arguments are not primarily made by tying claims to ultimate foundations and making them logically irrefutable. Rather, moral justification is validated through social practice, in communities of conversation creating shared vocabularies (Rorty 1979, 170–73). This means that the creative 'redescription' of a moral stake is prior to and more fundamental than logical reasoning within the parameters of a collectively established narrative (Rorty 1989, 3–45). A reconstruction of social values must therefore grasp the vocabularies and moral narratives that are shared in a political community. Rorty also emphasizes that shared vocabularies are only valid for a specific cultural

community, a political 'we' such as 'we liberals', the community to which he addresses his political convictions (Rorty 1989, 44–69). This, again, stresses the contingent and contextual nature of moral arguments.

An aspect that is not reflected in Rorty's 'ethnocentric' account of moral valuation is the fact that communities and their moral vocabularies are not essential and homogeneous, but overlapping and contested. Communities are inevitably 'imagined' (Anderson 1983), and there are different ways of imagining the political 'we'. This insight is more fully developed in the pragmatist sociology of critique that has been put forward by Boltanski and Thévenot (2006), most prominently in *On Justification*. The authors show that social actors – in their case, the actors of 20th century French industrial society – create and criticize social hierarchies on the basis of a plural set of valuation systems that are not reducible to each other. These different 'polities' [*cités*] or 'orders of worth' allocate moral praise and blame according to very different substantive standards. Yet, they all share a set of generic features that make them socially acceptable as a full 'model of legitimate order': a full-fledged order of worth specifies a common good relative to a political community, and it offers a concomitant rationale for determining the unequal moral status of the members of the community (Boltanski and Thévenot 2006, 66). Furthermore, it is equipped with social artifacts that enable concrete evaluative practices, thus making up the 'common worlds' (Boltanski and Thévenot 2006, 125) of the order.

The aim of this article is not to transpose the substantive liberalism of Rorty or the substantive orders of worth theorized by Boltanski and Thévenot to the context of global health politics. Their orders (originally six) were developed to account for critical practices in the French industrial world, and are tailored to this historical context.[2] Rather, I use the concept of orders of worth as a generic heuristic for reconstructing repertoires of evaluation as shared moral narratives that are enacted through specific devices and institutions. This heuristic allows for reconstructing forms of justification in different domains of global society including global health. Its main elements can be summarized as follows: orders of worth are based on a notion of the *common good* and a concomitant conception of the political *community*, conceptions of *virtue* and *deficiency*, and a repertoire of *valued objects* and *dystopian objects* through which controversial issues can be interpreted and classified. Through these elements, orders of worth resolve conflicts about distribution and moral hierarchy.

[2] Boltanski and Thévenot (2006) delineated a market order, an inspired order, a domestic order, an order of fame, a civic order, and an industrial order. Subsequent studies have also investigated other orders such as ecological justifications (Lafaye and Thévenot 1993) or the project-based 'new' capitalism (Boltanski and Chiapello 2006).

Thus, a distinct notion of the common good not only defines who 'we' are (see Rorty 1989, 44–69), but also offers a rationale for deciding who is more and who is less deserving. In the words of Boltanski and Thévenot, an order of worth is based on a 'principle according to which the members of a *polity* share a *common humanity*' (2006, 74, emphasis in original), and thereby posits a 'form of fundamental equivalence' (Boltanski and Thévenot 2006). The notion of a *common* humanity is formally egalitarian, presuming that in principle moral worth can be attained by all members of the community. For example, in Boltanski and Thévenot's 'market' order of worth, the common humanity of the members consists in their status as 'individuals' who exchange goods among each other but who cannot themselves be exchanged like goods. The market constitutes a community of (potential) property holders who are no one else's property and who strive for the common good of a functioning marketplace (Boltanski and Thévenot 2006, 79). This distinguishes the market order from orders such as the 'civic' order of democratic rule, where the members are defined by their common subjugation to a sovereign *volonté générale* (Boltanski and Thévenot 2006, 107–17).

Yet at the same time, the fundamental equality among the members of a community also implies that inequalities are justifiable and deserved due to the members' moral conduct (Boltanski and Thévenot 2006, 75). The criteria for formal equivalence also offer principles of stratification. Thus, *virtue* and thereby a higher moral status is associated with a personal 'sacrifice' for the common good – for example, when lazy consumption in the 'industrial' order is given up in favor of higher productivity (see below, The order of production section). That someone renounces 'self-centered pleasure' for the 'common good' makes their privileges acceptable. It is the 'investment formula […] that links the benefits of a *higher state* to a *cost* or a *sacrifice* that is required for access to that state. The formula of sacrifice or economy is the regulator that suppresses the tension between a common humanity and an ordering of states' (Boltanski and Thévenot 2006, 76). The sacrifice is beneficial for everyone, for example, by furthering productivity, and therefore justifies a higher moral status. Conversely, a lower moral status is justified when a member of the community prefers to be selfish and thus does not further, but may even harm, the common good. The deficient characteristics that place someone on a lower rank are precisely those pleasures or selfish behaviors that the virtuous members of the community forego for the higher common good.

Importantly, the plurality of evaluation schemes implies that what may be valued 'self-centered' and 'deficient' in one order can at the same time be a worthy contribution to the common good within another moral order. For example, what may be an act of loyalty and fidelity in the 'domestic'

order of worth might have to be sacrificed for greater creativity and innovation in the 'inspired' order of worth (Boltanski and Thévenot 2006, 76–78). Such rivaling evaluations of certain traits and behaviors are central to moral arguments in complex societies.

While orders of worth thus offer *generalizing* principles for attributing moral worth, this is not to say that they are purely theoretical. They are not philosophies that are grounded in objective reason, but critical repertoires that must be used in justificatory practices (Kornprobst 2011). Hence, each model of justice not only comes with principled evaluation criteria, but also with a worldly repertoire of *valued objects* that are used to measure moral worth. Indicators such as classificatory schemes (e.g. a publication index), professional roles (e.g. professorships), status symbols (e.g. a big office), or behavioral standards (close PhD supervision) are essential components of an order's moral 'world' (here academia as the 'world' of science).

Finally, although it is not stressed in Boltanski and Thévenot's account, a nonetheless critical implication of justificatory narratives is that they are constructed in opposition to a dystopian vision that must be avoided. Each account of the common good also provides a more or less explicit account of the major threat against which the common good is to be defended, that is, it implies a narrative 'emplotment' of the order's central elements (see White 1973). The pertinence of the common good is sustained by a threatening scenario and indicators of its imminence. These are an order's *dystopian objects* or things-to-be-averted. We will see below that in the politics of health, dystopian visions such as the emergence of super-viruses or the disempowering effect of 'medicalization' are important components of moral narratives about global health. These negative scenarios are as important as the positive visions, if not constitutive thereof.

The heuristic of orders of worth allows for a thick and comparative reconstruction of moral valuation schemes, which can be applied to many domains of global politics and their imagined communities. It also contributes to the emerging literature on practices in international politics, a literature that is centrally concerned with understanding how actors use their social 'background knowledge' (Adler and Pouliot 2011, 7) in pragmatic and creative ways. Orders of worth provide the background knowledge and the practical devices for resolving conflicts about moral status and unequal distribution. Their plurality and the actors' critical capacities ensure that moral judgment is not predetermined in a given situation (Wagner 1999), and that evaluations always remain contestable (Gallie 1956, 172).[3]

[3] This distinguishes orders of worth from the communitarian idea of 'spheres of justice', that is, spheres that are exclusively applicable to the distribution of specific social goods (Walzer 1983). The pragmatist approach to valuation does not delineate social domains that are

In the following section, I use this heuristic to reconstruct the contested value of health in global politics.

Four moral orders of health in global politics

This section delineates conceptions of health on the basis of the common good that they articulate. Using the analytical framework outlined above, I distinguish between four orders of worth and their distinct rationales and devices for evaluating health in global politics. These are the order of survival, the order of fairness, the order of production, and the order of spirit (see Table 1). Each of them provides its own conception of the community that is to be healthy (e.g. 'we bodies' or 'we souls'), of the threats to 'our health' (e.g. Mother Nature or medical technology), and of the virtuous sacrifice that is required to maintain health (e.g. forgoing economic advantages or forgoing lazy habits).

Table 1 presents an overview of the four orders and their central components. To provide a reconstruction that is valid for today's normative order, I do not follow the strategy of *On Justification*, which is to reconstruct normative archetypes from European philosophical classics. Instead, I draw more recent authors whose writings date back no further than the 1970s and who are widely read among global health scholars and practitioners. The authors that I will discuss are academics who often work as policy consultants. Their writings explicate the rationales for different understandings of health, rationales that are often applied to specific cases or problems, but always developed against the background of more general evaluative principles. While I treat authors as 'grammarians' of prominent valuation schemes (Boltanski and Thévenot 2006, 71), I draw on their work eclectically and do not impute on any of them that he or she fully and exclusively subscribes to one of the four orders. People are not theories. They are, however, important narrators who shape our ideas about health, justice, and healing.

The second component of this reconstruction will be to map practical repertoires such as cognitive tools or policy programs that are used to measure and promote health in global politics. This again helps to ground the conceptualization in current policies and practices. Of course, this selection of moral orders cannot exhaust all the possible vocabularies through which global health can be evaluated. The focus is on prominent Western texts and central global policies in order to comprehend how the modern core of global health governance is essentially contested.

exclusively subject to one order, but assumes the coexistence of rivaling orders. The lack of a preconceived division of labor between them makes the ordering principles ultimately incompatible (Boltanski and Thévenot 1999, 363).

Table 1. Four moral orders of global health

Common good	Survival	Fairness	Production	Spirit
Community	We species	We liberals	We bodies	We souls
Virtues	Vigilance, information sharing, prioritization of security	Cosmopolitan solidarity, generosity	Efficiency, planning, economic rationality	Autonomy, wholeness, acceptance of pain and death
Deficient (selfish) characteristics	Prioritization of short-term economic gains over security	Exploitation of privileges, lack of empathy	Waste, laziness, shortsightedness, routine	'patient' identity, delusions about modern medicine, technocratic rationality
Valued objects	Global outbreak and surveillance cooperation, e.g. through GOARN or GISRS, and the IHR,[a] epidemiological surveillance, medicine and epidemiology, law enforcement	Human rights treaties, WHO constitution, Alma Ata Declaration, redistributive institutions and universal coverage	Targeted interventions, e.g. GFATM, essential service coverage, DALYs, health economics and behavioral economics	Believers, coping ability, compassion, religious health assets, religious coping
Dystopian objects	Emerging diseases and killer viruses, Mother Nature	Capitalism, authoritarianism, intellectual property rules/ patents (TRIPS)	Resource scarcity, population growth	Technology, bureaucracy, hospitals and retirement homes
Relevant authors	David P. Fidler; Laurie Garrett; Adam Kamradt-Scott	Thomas Pogge; Lawrence Gostin; Paul Farmer; Michael Marmot	Jeffrey D. Sachs; Abhijit Banerjee and Esther Duflo	Ivan Illich; Stefan Elbe; Alison Howell

GFATM = Global Fund to Fight AIDS, Tuberculosis and Malaria; DALYs = disability-adjusted life years; TRIPS = Trade-Related Aspects of Intellectual Property.

[a] These are the Global Outbreak Alert and Response Network (GOARN) and Global Influenza Surveillance and Response System (GISRS), and International Health Regulations (IHR), all managed by the WHO.

The order of survival

The *order of survival* is a widely narrated model of global health that emphasizes humankind's biological vulnerability to microbial threats. It is central to the global health security debate, which has intensified enormously over the last decade and has been analyzed in depth by scholars of global health securitization. This debate articulates health security not as a broader theme of social security, but rather accentuates the existential meaning of security as survival (see Howell 2014). Survival is at stake in the face of the existentially threatening scenario that contagious pathogens pose to a globalized society. Similarly to IR realism, this account is based on an ethics of worst-case thinking, where one has to prepare for the ultimate threat (e.g. Mearsheimer 2001). Yet in contrast to IR realism, the threat to survival does not reside in armament and war, but in the vicissitudes of the natural environment. It is the fear of killer viruses and the vulnerability of humans to old and emerging diseases that inform the order of survival. In the words of Fidler, a scholar of global health law, the dystopian scenario that humans have to fear is 'Mother Nature' and the pathogens that it 'hurls … at a world still unprepared for more killer microbes' (Fidler 2004b, 3).

In this scenario of humans against Nature, the political community is defined on the basis of shared biological characteristics of all humans, namely our shared vulnerability in the face of contagious disease. Our common humanity thus is defined by our identity as a *species* which has to be wary of the next major pandemic. The threat of contagious outbreaks forges a political *we* that is 'united by contagion'.[4] This community must overcome nationalism and interstate rivalry in order to protect humankind against deadly infections (Fidler 2004a).

The historical context within which the order of survival has gained salience is the renewed concern with emerging and re-emerging infectious diseases such as Ebola, AIDS, or SARS since the late 1980s. Narrators of the survival imperative, among them best-selling US journalist Garrett, have therefore warned that despite all medical progress humankind is ill-prepared to handle a future 'coming plague' (Garrett 1994). As the concept of 'emerging infectious diseases' gained traction within 1990s US national security debates, concerns of global health security also became paramount in international health institutions (Weir and Mykhalovskiy 2010).

The institutional context in which these debates have unfolded is the legal regime for international surveillance and outbreak response, which is centered on the International Health Regulations (IHR) administered by the

[4] This is the subtitle of Zacher and Keefe's (2008) book *The Politics of Global Health Governance*.

WHO. The IHR have been subject to a watershed reform in 2005, in the wake of the 2002/3 SARS outbreak. The shift from the 'old' to the 'new' IHR meant that the WHO gained much more discretion in reacting to outbreaks. Before 2005, it had been constrained by a sovereign veto – meaning that it could only become active when states reported outbreaks on their territory and asked for WHO support – and an IHR treaty that was limited to a few quarantinable diseases such as cholera and yellow fever. Only after 2005 was the WHO allowed to act more independently, and thus to draw on non-state epidemiological intelligence and to decide by itself when to declare a disease or a similar health threat an international health emergency.

Scholars of international law and political science have discussed this transition as an institutional progress that comes closer to realizing the imperatives posed by the order of survival than the pre-2005 IHR. In a globalized society where 'germs do not recognize borders' (Fidler 2004b, 13), priority must be given to outbreak surveillance and control, beyond narrow 'Westphalian' sovereignty concerns (Fidler 2004a, 257). The old IHR had failed in this regard. They allowed states to block surveillance and response measures, and were thus vulnerable (if not tailored) to states' economic selfishness. States could keep on protecting their economic interests and avert costly disruptions of travel and trade incurred through quarantines and border controls (Fidler 2004b, 27–29): 'The short-term gains from dissimulating on infectious disease outbreaks outweighed any longer-term costs from being seen as *selfish* in connection with public health issues' (Fidler 2004b, 115, emphasis added). Such behavior that is deficient from a survival perspective, namely that states insist on 'narrow, insular national interests' (Fidler 2004b, 130), has been made less likely through the IHR reform – even though the IHR and the WHO's response capacity are still inhibited by certain mechanisms of state oversight (Kamradt-Scott 2011, 810–11).

The heroes and villains in this order are thus clearly identifiable. An example of reprehensible conduct is provided by China's behavior during the 2002/3 SARS outbreak. When SARS, an unknown and highly lethal lung disease, spread on Chinese territory, Chinese authorities put global health at risk by suppressing vital epidemiological information (Fidler 2004b, 107–14). A contrasting example of virtuous conduct was the role that Singapore played during SARS. This country had already been removed from the WHO list of SARS-affected countries when a new outbreak occurred within its borders. Despite the foreseeable economic damage that would result from giving up its 'clean bill of health', Singapore made a sacrifice for the common good and reported the case, thereby remaining on the list for 20 more days (Fidler 2004b, 128). 'This incident illustrates Singapore's formulation of its national interest in a manner that fully reflected the importance of the GPGH [global public good for health]

of accurate global SARS surveillance' (Fidler 2004b, 128). Virtuous behavior in the order of survival is a sacrifice of short-term economic interests for the greater common good of survival, realized through collaboration in global surveillance and outbreak control.

Accordingly, the valued devices in this order are regulations such as the new IHR, as well as technologies of epidemiological intelligence and coordination such as the WHO's Global Outbreak Alert and Response Network (GOARN) or its Global Influenza Surveillance and Response System (GISRS). These devices assign an important role to physicians and epidemiologists who provide surveillance, vaccination, and treatment. An additional device, which has not been institutionalized but would be desirable for a 'world' of survival, is stricter enforcement provisions for those who do not comply with their reporting duties. In this vein, the political scientist and health consultant Kickbusch (2003) proposed that states

> Explore the possibility of the UN Security Council, the World Trade Organization and the International Monetary Fund imposing sanctions on countries that do not adhere to global health transparency and their obligations under the International Health Regulations and, conversely, develop an incentive system for countries that act as responsible global citizens.

This call for enforcement has been reiterated during the conflict over Indonesia's refusal to share bird flu specimen, which I have outlined in the introduction of this article. When Indonesia interrupted its virus sharing practice in 2007, Garrett and Fidler warned of a 'United Nations Security Council intervention on the grounds that failure to share viruses imperils global health security and international security' (Garrett and Fidler 2007, 1713; see Holbrooke and Garrett 2008). Similarly, in the light of the 2014 West African Ebola epidemic, the WHO secretariat has called for sanctions against states who fail to invest in outbreak preparedness (Miles 2015).

To summarize, the order of survival is tailored to a global society united by its biological vulnerability to contagious disease. Virtuous behavior consists of minimizing microbial threats to the human species, and of sacrificing parochial economic interests for the higher value of common survival. The emergency ethics of this order imply that where survival is at stake, human rights may need to be curtailed, for example, when isolation and quarantine measures must be imposed: 'At times, governments may need to infringe on civil and political rights in order to deal with an infectious disease' (Fidler 2004b, 152). The possibility to do so should be legally circumscribed, yet achieving effective protection is the ultimate evaluative benchmark (Fidler 2004b, 153). By contrast, in the health-as-fairness order of worth, rights are not a limiting condition but the essence of global health.

The order of fairness

The order of fairness is grounded in the language of human rights, which is increasingly invoked in global health conflicts (Inoue and Drori 2006; Youde 2008; Reubi 2012). From the fairness point of view, the problem of health is not one of biological vulnerability to Nature, but a problem of distributional (in)justice and thus of health equity and non-discrimination.[5] The underlying notion of community is that we are rights-bearers who owe each other an equal share of the social and medical goods potentially available. The focus here is on those afflictions which could be prevented, alleviated, or cured 'in an age of great affluence' (Farmer 2003, 6), but which are rampant due to social injustice. Health is above all compromised by social inequalities and the forces that produce them.

Different authors have problematized health inequality with different terminologies and foci. The physician and anthropologist Farmer (2003, 20) speaks of 'structural violence' to designate the human-made conditions (meaning economic inequalities as well as political violence) that impair the health chances of the disadvantaged. The epidemiologist and public health scholar Michael Marmot speaks of an unequal distribution of the 'social determinants of health' such as housing, employment, or education. This term has gained salience through the WHO Commission on Social Determinants of Health (2008) chaired by Marmot. The political philosopher Pogge blames the global economic order for producing 'avoidable mortality and morbidity in the developing world' (see Pogge 2002, 15–20; Farmer 2003, 216–20; Pogge 2005, 193). He criticizes the intellectual property regime around the World Trade Organization's agreement on Trade-Related Aspects of Intellectual Property for making vital treatments inaccessible for many people (Pogge 2005, 186). The dystopia of the order of fairness is a system of '*market-based medicine*' (Farmer 2003, 160, emphasis added).

Thus, the main moral deficiency in the order of fairness is being *complicit* in this exploitative system of structural violence. This is a moral failure especially of Western governments and their citizens, who are the originators and main beneficiaries of the global economic order and thus 'participate in depriving [the global poor] of the objects of their most basic rights' (Pogge 2002, 23). Virtue, accordingly, can only be afforded by the privileged. It requires that 'the strong' commit (or are committed) 'to protect the livelihood and dignity of the vulnerable' (Pogge 2002, 5).

[5] In the words of the 1946 WHO constitution: 'The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition' (2006, 1).

It is the economically and socially privileged who have to make a material sacrifice for 'social justice' (Farmer 2003, 152) or, in the law scholar Gostin's (2014, 412–40) words, for a system of global health 'with justice'.

Given the absence of a global welfare state, the 'world' of fairness in global health is mostly hypothetical. To remedy this deficit, Pogge has proposed an institution that would realize the order of fairness in global society, the Health Impact Fund. It is a redistributive scheme where the privileged renounce a small proportion of their wealth to support a 'rule change that benefits *others* (poor people in the developing world) at our expense' (Pogge 2005, 193, emphasis in original). This tax-financed fund would support health interventions that benefit the poor and for which no profitable market exists in the current system.[6] Western tax payers would earn the most deserving moral status in this system because they would pay for the Fund (Pogge 2002, 11).[7]

Next to such institutional designs that would mirror national welfare states at the global level, the valuable objects of the order of fairness are international *human rights treaties*: the WHO constitution, which stipulates the human right to health (see footnote 7), and the Declaration of Alma Ata, which was endorsed at the joint WHO/UNICEF Conference on Primary Health Care in 1978 (Cueto 2004). The Declaration affirms the principle of social equality and stresses the importance of public spending for health.[8] It is a central point of reference for the advocates of redistributive institutions and of universal coverage of health services (WHO 2010).

With its emphasis on social equity, the order of fairness envisages a political community of mutually responsible bearers of human rights. It is a community of liberals, in the sense that they give priority to avoiding cruelty and mutual harm, being bound to each other by duties of justice (Rorty 1989; Pogge 2002, 13). This distinguishes it from the economic view of humans and their body that is articulated in the order of production.

The order of production

We have seen above that the survival perspective on health envisages humankind as a biological species that is existentially threatened by Nature. The *production* perspective on health also stresses human biology, but does so through the lens of natural and economic scarcity. From this perspective, humans are conceived of as bodies with quantifiable functions. *We bodies*

[6] See http://healthimpactfund.org/ (accessed 28 February 2014).

[7] No sacrifice would be asked from pharmaceutical companies, however, because collaboration with the Fund would be made profitable for them (Pogge 2005, 188–94).

[8] http://www.who.int/publications/almaata_declaration_en.pdf (accessed 28 January 2015).

form a political economy where the number of our healthy life years makes us more or less productive. Improving health then means to make cost-effective interventions in order to maximize the number of our productive life years.

This economic model of health has gained prominence in international politics through two reports published under the auspices of the World Bank and the WHO, respectively. The first was the 1993 World Development Report *Investing in Health* (World Bank 1993), which heralded the Bank's new dominance in international health and became notorious for its advocacy of cuts in government spending for health (World Bank 1993, 10). The more recent report of the WHO's Commission on Macroeconomics and Health (CMH), by contrast, is mainly an advocacy tool for development funding in low- and middle-income countries. Its focus is on 'the world's poor' (CMH 2001, 1). It is mainly economists who have shaped the productive view of health. One of them is Jeffrey D. Sachs, a leading development researcher who among his many functions chaired the CMH and served as a special adviser for the UN Millennium Development Goals. Contemporary proponents of behavioral economics such as Esther and Abhijit have further elaborated the productive conception of health and the means of realizing it.

In the order of production, health is valued as a determinant of economic development. Though it is granted in publications such as the CMH report that '[i]mproving the health and longevity of the poor is an end in itself', what matters is that 'it is also a *means* to achieving the other development goals relating to poverty reduction' (CMH 2001, 1). Various causal models serve to corroborate the health–production linkage, for example, the positive correlation between high life expectancy at birth and economic growth rates (CMH 2001, 24). They demonstrate that health is closely tied to the desirable *common good* of development. Since it is beneficial to 'invest' in health, the order of production also comes with a formula for measuring the gain from such investments, namely the metric of disability-adjusted live years (DALYs).

DALYs were constructed by the WHO and the World Bank in the early 1990s. They measure productive life years, that is, 'healthy life years lost because of premature mortality with those lost as a result of disability' (World Bank 1993, 1). Healthy life years, in turn, maximize the 'economic well-being' (CMH 2001, 30) of individuals throughout their 'life cycle' (CMH 2001, 33). This is a measure targeted at relative productivity instead of absolute survival. The preference given to the quality rather than the quantity of lives is also expressed in the expectation that 'improvements in health' lead to 'reduced population growth' (CMH 2001, 3), because families 'would also choose to have fewer children, secure in the knowledge that their

children would survive, and could thereby invest more in the education and health of each child' (CMH 2001, 2). The focus is on maximizing vital and productive live years, not on making individuals survive.

DALYs not only offer a quantifiable conception of health, but also serve as a compass for making the right policy choices: 'An important source of guidance for achieving value for money in health spending is a measure of the cost-effectiveness of different health interventions and medical procedures that is, the ratio of costs to health benefits (DALYs gained)' (World Bank 1993, 5; see CMH 2001, 12). Priority interventions substantively reduce the 'burden of disease' as measured by DALYs (Murray *et al.* 1994), because they target those illnesses which affect individuals (especially the poor) and that harm the economy most strongly. They are efficacious and cost-effective, so that the 'social benefits exceed the costs of interventions', 'with benefits including life-years saved and spillovers such as fewer orphans or faster economic growth' (CMH 2001, 10). Exemplary high-impact interventions (yielding many DALYs per dollar invested) are vaccinations against harmful infectious diseases such as measles or polio, or the provision of highly effective treatments, for example, against tuberculosis (WHO 1999; CMH 2001, 44). These measures and the institutions that implement them, for example, the Global Fund to Fight AIDS, Tuberculosis and Malaria, are therefore highly valued devices in the order of production.

The moral imperative to *make smart choices* pertains not only to policy makers but also to individuals. They should also seek to maximize healthy life years per investment (see CMH 2001, 47), through a 'logic of self-investment' akin to human capital theory (Kenny 2015, 13). This necessity that especially 'the poor' must be incentivized to invest their scarce resources in a way that maximizes their health and life chances has become the focus of a rapidly growing literature in behavioral economics, which often uses field experiments to find out how development can be fostered at the micro-level of individual choices (Banerjee and Duflo 2011). The poor must be induced, for example, to spend additional money on nutritious instead of tasty food, because tasty food is costly without making them more productive (Banerjee and Duflo 2011, 22–28). These healthy choices evidently involve a *sacrifice*, namely the sacrifice of short-term pleasures. Poor people should opt for eggs and bananas, even if they wish to go for 'a more exciting diet' (Banerjee and Duflo 2011, 27). This allows them and their children to work better, learn better, and live longer and more productively. Policy makers must give up routines and inefficient bureaucratic structures in order to invest in health rather than in patronage or corruption (see World Bank 1993, 4). But also wealthier people must learn to be less *wasteful, inefficient, and shortsighted*. Our impulsive behaviors and short-term needs become aspects of our bodies that we have to factor

into our decisions, so that we become competent managers of our health over the entire life span (Thaler and Sunstein 2009).

The order of spirit

In contrast to this economic morality of decomposing lives into productive units, the spiritual order of worth is geared toward cultivating the integrity of the soul. The order of spirit is a central component of modern debates about global health, although it is often overlooked as the pre-modern and religious 'other' to modern global health. Yet, the ideals of wholeness and of personhood and the vision of a *community of souls* stretch far beyond religious connotations. The order of spirit rather makes 'religion' an integral component of secular health ethics.

The order of spirit is antithetical to the productive order and its disintegration of human beings into quantities of functionalities, or healthy life years. From the spiritual point of view, the individual person and its moral capacities are the center and source of health. This moral ideal of personhood gains its meaning and importance in opposition to a specific dystopia, namely the far-reaching authority of modern medicine. 'Medicalization', that is the tendency to treat all kinds of moral and social problems as sickness that must be solved by medical experts, has become a central concern of medical sociologists (Conrad and Schneider 1980; Elbe 2010; Howell 2014). This strand of critical sociology echoes the societal suspicion of the medical profession and modern technology more generally, which has been ever present since the 'golden era' of modern medicine came to an end after the World War II. That suspicion is present in both secular and confession-based writings, where medicine is criticized for undermining the autonomy of the self and for decomposing humans into sick parts that are referred to the 'repair factories' of modern hospitals, instead of seeing and appreciating the 'wholeness' of humans (McGilvray 1981). Or, as Foucault (1989) put it, the 'medical gaze' envisions humans as the carriers of localized symptoms amenable to clinical treatment.

The order of spirit challenges this power of medicine because it undermines two faculties of persons that are crucial for health: coping ability and compassion. No one has articulated these vices of medicine more vividly than the dissident Catholic theologian and outspoken cultural pessimist Illich (1976), whose book *Medical Nemesis* (also known *as Limits to Medicine*) was an international bestseller in the 1970s (Cueto 2004, 1865). The book summarizes research on the limited role of medicine for the general improvement of health outcomes in modern societies (e.g. McKeown 1976) and on the negative side effects of medical treatments. In addition, Illich's claim that the 'medical establishment' is 'a major threat to health' (1976, 3) addresses more

fundamental concerns regarding the moral costs of medicalization. The first is that the reliance on doctors undermines the human capacity for suffering and self-care, and thus for coping with ailment and death. Where humans are subject to medical surveillance, categorization and treatment from birth to death (which is now experienced in hospitals with doctors on the bedside), they lose what health is actually made of: an equilibrium with nature sustained by 'autonomous personal, responsible coping ability' (Illich 1976, 7). *Coping ability* means, for Illich, that the sick do not focus their 'entire expectation […] on science and its functionaries [but] seek a poetic interpretation of their predicament or find an admirable example in some person—long dead or next door—who learned to suffer' (1976, 114). Second, medicine not only undercuts personal autonomy and coping abilities. It also harms the moral ability to care about others and to live with compassion and solidarity: 'The siren of one ambulance can destroy Samaritan attitudes in a whole Chilean town' (Illich 1976, 8). The ambulance makes us lose our community of moral subjects who are capable of 'compassion' due to the 'certainty that we share the experience of pain' (Illich 1976, 141).

In today's global health regime, these spiritual virtues of self-care and compassion are not just the views of outsiders or transcendent values that are irrelevant to practice. On the contrary, global health is marked by the emergence of elaborate devices that tap spirituality for health policy. Like global governance more generally, global health nowadays reserves a special place for 'religion', whose generic meaning is a genuinely secular construction enshrined in myriad new 'religious' and 'interfaith' institutions (Shakman Hurd 2015). For example, forms of 'religious coping' have become a main concern of medical researchers seeking to identify the positive health impact of 'benevolent religious reappraisals, religious forgiveness/purification, and seeking religious support' (Pargament *et al.* 2000, 519). Likewise, 'compassion' has been conceptualized as a universal religious trait that can be found in all world religions and that can have a particular health value (Hanrieder 2017). In this vein, researchers affiliated with the World Bank have developed indicators of the 'faith factor' in religious health service provision and operationalized 'compassion' as the preparedness of religious health workers to provide services below market value (see World Faiths Development Dialogue 2012).

The worthy *sacrifice* of health professionals and volunteers thus consists in foregoing higher incomes out of empathy with the sick. Yet, not only health providers and caregivers can attain a higher moral status in the order of spirit; virtue is also attainable for patients who demonstrate *coping abilities*. The sacrifice of the sick, and ultimately of all mortals, is a willingness to learn *the art of suffering*, or, in Illich's provocative terms, even the 'peaceful expectation of death' (1976, 273). Being ready to give up

illusions about medical salvation, and to accept the reality of pain and death, is an achievement of the soul. It is the privilege of the inspired layperson, not the health professional.

Contest and compromise

The four orders distinguished above indicate the pluralist repertoire through which behaviors and policies are evaluated in the global health discourse. I have suggested that each order produces distinct moral hierarchies due to distinct conceptions of the common good, which are ultimately irreducible to each other. The reconstruction has also shown that the different orders are articulated in opposition to other orders, and thus directly contradict valuations supported by alternative repertoires. Since there is no preconceived division of labor between the four orders, none of them exclusively governs its 'own' sphere of global health (see footnote 3). Rather, concrete evaluations can always be contested with reference to competing evaluative schemes. Accordingly, real-world settlements are rarely a pure reflection of any single order, but combine elements of different orders. This section discusses the nature of these combinations. I propose that real-world settlements are *compromises*, which satisfy some, but rarely all, concerns of individual orders (Boltanski and Thévenot 2006, 275–92).[9] Concrete settlements involve trade-offs between the goods of each order, which do not reflect underlying (meta-)principles of the global health discourse. In the following, I specify the moral pluralism of the global health discourse and the resultant logic of compromise by highlighting first, the *irreducibility* of the four orders (which hinders principled compromises), second, the *divisibility* of their respective goods (which counteracts a lexical order between them), and third, their *creative* enactment in contested situations (which ties evaluations to a politics of reality).

First, the underlying values of the four orders are irreducible and therefore principally incompatible. In real-world settings, the actors involved in global health policy making can rarely choose to follow purely one order. Rather, they seek to satisfy several moral concerns and therefore must draw on elements from different orders. Or, as theorists who draw on Foucault's ideas on biopolitics and neoliberal governmentality put it: the rationale of modern government is to achieve the security (i.e. survival) *and* the productivity of the population, and in doing so, it has to respect the moral limits set by political liberalism (i.e. fairness) and individualism (i.e. spirit; see Foucault 1991; Elbe 2009). Modern governmentality is a combination of the four orders. However, this generic insight does not provide a rationale for resolving

[9] Note that this section only discusses the possible *interpretive* meanings of compromises, not their *causal* drivers (such as power vs. persuasion, cf. Hanrieder 2011).

conflicts within the global health discourse, given that the goods envisioned by each of the implied orders cannot be realized fully and simultaneously. Compromises involve trade-offs.

This tension can be illustrated, for example, with the contested principle of universal health coverage (UHC), which is part of the United Nations Sustainable Development Goals. Actors debating the precise meaning and realization of this goal disagree over the extent and type of services that must be available to all members of a community, and thus over the right balance between the aim of efficient resource allocation with the aim of equitable access to health services. From a pure viewpoint of the order of production, the resources available in a country's health system should be allocated in a way that maximizes the health output per dollar. This, however, conflicts with concerns about health equity that are prioritized in the order of fairness. From this perspective, special care and expensive services for marginalized or disadvantaged people such as people living with disability are more important than efficiency concerns (Friedman 2016). The actors involved in such debates have to forge compromises for which no principled solution exists, only situated compromises.

Second, compromises are facilitated by the fact that the goods promoted in moral conception of health are divisible: they can be realized to greater or lesser extent, and therefore need not follow an all-or-nothing logic. This prevents, for example, that settlements must be based on lexical reasoning, where 'more fundamental' concerns such as security must be addressed first, before other goods can be aspired for. Like security in general, global health security is never guaranteed, and techniques for realizing it at best reveal the fragility of any institutional solution (see C.A.S.E. Collective 2006). Thus, the extent to which health policies should follow a security rationale remains contestable and is, in fact, contested in global health institutions. This can be observed in times of global health emergencies, when states disagree about the permissibility of security measures. States that fear the spread of contagious diseases often defend strict measures such as quarantines or travel bans for people from affected zones. By contrast, affected states and the WHO regularly condemn 'excessive' security practices as further strains on a country's economy and health system, and thus as ultimately counterproductive. Therefore, the role of the WHO as envisaged by the IHR is to mediate between security and productivity concerns and to come up with recommendations about the maximum permitted security measures (see above, The order of survival section).[10]

[10] Many states fail to comply with these recommendations during global health emergencies (Worsnop 2016).

Third, such compromises are thus always contextual and must be actively constructed by the actors involved. Deciding how concerns from different orders should be combined in concrete situations requires creativity, as each specific compromise not only determines how rivaling principles should be applied to a given situation but also fixes the very interpretation of specific situations, and thus the parameters of the respective moral choices. For example, the debate about UHC is not only about the allocation of health policy resources that are available in a country, but is also a debate about the resources that could and should be made available for the health system, for example, by negotiating the prices of medical products (Friedman 2016). As in the politics of global disease outbreaks, these are also debates about what is realistic, which values are at stake and what the trade-offs are. Stabilizing such interpretations requires that actors mobilize narratives and devices in a way that creates a fit between evaluative repertoires and contested situations. Evaluations are thereby a test of reality as much as they are a test of worth (Boltanski 2011).

The 'reality' of global health may be temporarily stabilized in institutional settlements, but is always at stake in justificatory practices. Such an active construction of the reality of global health can be observed, for example, in the emerging debate about 'digital health' (or eHealth, for electronic health). With the rapid digitalization of health services and communication, intensive moral debates have begun about the moral status of new technologies such as genomics and genetic research, telemedicine, precision and personalized medicine, sensors, big data analysis, and health applications ('apps') for private consumers. In these debates, elements of each order are mobilized to debate the meaning of health in the digital age. The order of survival is invoked to highlight the promise of digital epidemiology, for example, new surveillance possibilities that help humans defend themselves against global killers (Eckhoff and Tatem 2015). The order of fairness perspective is invoked, for example, where digital technologies are praised as equalizers that ensure a more equitable access to health services, also for remote and underserved populations.[11] The order of production is invoked by those who herald health intelligence as an efficiency enhancer, which facilitates smart investments in what actually works.[12] Finally, the perspective of spirit gains salience in the digital health debate due to the growing emphasis on the value of 'privacy' (Youde 2010, 177–88). 'Privacy' seems to re-articulate the meaning of personal autonomy and the integrity of the soul for the digital age.

[11] See https://www.ruralhealthinfo.org/topics/telehealth (accessed 15 May 2016).

[12] See http://health-outcomes.org/2015/09/17/how-digital-health-can-improve-care-efficiency/ (accessed 4 November 2015). Individuals, too, can improve their health choices and maximize their healthy live years, for example, with the help of health apps that induce them to change their routines.

The extent to which these concerns are addressed in emerging policies in the EU and the WHO[13] will shape the global 'reality' of eHealth, and produce new devices through which the meaning of health can be narrated and evaluated in the digital age.

This section's discussion of the principled divisibility and irreducibility of the four orders, thus, cannot substitute an in-depth reconstruction of empirical compromises between different orders. Global health remains essentially contested, especially but not only in highly dynamic fields such as eHealth. Through ongoing struggles, the moral repertoires will evolve as well. Yet, a glance at the ongoing eHealth debate also suggests that the basic repertoires will remain relevant and that the historical investments in evaluative devices will leave their mark on future contests and compromises.

Conclusion

In this article, I have reconstructed the different visions of a common humanity and its higher common good that are associated with the ideal of global health. I have distinguished between four orders of worth in global health: the order of survival, the order of fairness, the order of production, and the order of spirit. Each order provides different rationales and practical devices for distinguishing virtuous sacrifices from deficient selfishness, rationales which are irreducible to each other and not 'ordered' within one coherent master discourse. This leads to constant clashes about the value of health policies and practices, clashes which can lead to situated compromises but are unlikely to produce a generic and stable settlement. Order among the four orders is always contestable and precarious.

While the main ambition of this article has been to reconstruct the specific logics of praise and blame that are at play in the world of global health, the article also makes a broader contribution to the study of global norms through the concept of orders of worth. First, orders of worth offer a critical contribution to the study of global community and collective identity. They help to reconstruct how visions of global goods and a global community produce moral hierarchies. The reference to a community's common goods, however imagined, implies a rationale for discriminating between virtue and deficiency as well. This logic not only applies to health but to many so-called global goods. Thus, each conception of a global good such as development, security, or democracy also allocates blame and praise in specific ways, and thereby defines what is pro-social and anti-social within a

[13] See for example, the European Commission's eHealth action plans (https://ec.europa.eu/digital agenda/en/news/putting-patients-driving-seat-digital-future-healthcare, accessed 5 November 2015) or the WHO's work on digital technologies in the fight against tuberculosis (WHO 2015).

scheme. Future explorations and comparisons of valuation schemes in different issue-areas can further enhance our understanding of moral hierarchies in global politics.

Second, aside from this theoretical contribution to debates about global community, the conceptualization of evaluative repertoires and their practical components also serves an empirical objective. The framework of orders of worth facilitates thick reconstructions of evaluation cultures in different domains of global governance. In addition to highlighting that 'universal' values and forms of stigmatization are intricately linked, identifying the practical components of evaluative repertoires will also help to better understand *which* values and *which* stigmas 'the' international community produces (see Adler-Nissen 2014). This heuristic also facilitates comparisons across policy fields, world regions, and policy levels. Evidently, this empirical ambition also implies that the four substantive orders proposed herein are only useful to the extent that they shed light on concrete justification practices in the global health domain. They offer one possible reconstruction that is certainly not exhaustive or without alternatives. Still, the brief discussion of the digital health discourse above suggests that even seemingly transformative developments for the field of health mobilize arguments along the lines delineated in this piece.

Finally, the question of *valuable emotions* deserves further scrutiny. As becomes evident, for example, in conflicts about production- vs. survival-based evaluations of health emergency measures, different orders of worth also come with different conceptions of appropriate feelings. While fear may be appropriate in the order of survival, impulse-control and dispassionate calculation are appropriate in the order of production. Likewise, I have argued that compassion is a valued moral sentiment in the order of spirit. Future attention to appropriate vs. guilty feelings can lead to productive cross-fertilization between the evaluation sociological approach put forward in this piece and the social psychological perspectives that are increasingly inspiring IR scholarship on emotions (D'Aoust 2014; Hutchison and Bleiker 2014). From the perspective of a moral economy of emotions, orders of worth are the cultural repertoires that constitute which moral sentiments are personally gratifying and socially rewarded – but potentially also contested and subverted.

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